Lawrence-Douglas County Fire Medical
Physician Certification Statement

1911 Stewart Avenue, Lawrence KS 66046
Office: 785-830-7040 Fax:785-830-7090

SECTION 1 – GENERAL INFORMATION

Patient Name: _____

Sending Facility: _____

Receiving Facility: _____

LDCFM Incident #: _____

Patient DOB: _____

Date of Transport: _____

SECTION 2 – TRANSPORT CATEGORY

Using the Patient Transfer Flow Chart, what category does this transfer fall into?

❑ **EMERGENCY TRANSFER** → Complete ***Section 3***

❑ **NON-EMERGENCY TRANSFER** → Contact **Alternate Transport Providers.** *if none are available, complete* ***Section 4***

❑ **ROUTINE TRANSPORT** → Refer to ***Section 5***

SECTION 3 – EMERGENCY TRANSFER

(1) What are the services that will be performed / available at the receiving facility that are not available at LMH? (check all that apply)

❑ Level I/II Trauma Center ❑ Neurosurgery ❑ Vascular Surgery ❑ CABG ❑ Electrophysiology ❑ Pediatric ICU ❑ Hematology

❑ Orthopedic Surgery ❑ Neuro ICU ❑ Burn Center ❑ AICD ❑ Interventional Radiology ❑ Neonatal ICU ❑ Urology

❑ Cardiothoracic Surgery ❑ Pediatric Specialty (describe below) ❑ Other Specialty (describe below) ❑ Other Procedure (describe below)

_____

(2) What are the patient's conditions / diagnoses that require the services indicated above? _____

_____

(3) In your professional judgement, is there a reasonable expectation that a delay in performing this transfer would (a) place the patient's health in serious jeopardy, (b) seriously impair bodily functions, or (c) result in serious dysfunction of any bodily organ or part? ❑ YES ❑ NO

↳ If "NO" skip to ***Section 4*** ↳ If "YES", describe the potential negative effects to the patient's health from delayed transportation:

_____

(4) If any hospital personnel will be accompanying the patient on the ambulance indicate their certifications below:

❑ ED Nurse ❑ Critical Care/ICU/Cath Lab Nurse ❑ OB/GYN Nurse ❑ Respiratory Therapist ❑ Other: _____

SECTION 4 – NON-EMERGENCY TRANSFER

LDCFM normally does not perform non-emergency transfers. Request a non-emergency ambulance service using your hospital's established procedures. Under exceptional circumstances, or when no non-emergency service is available for an extended period, call Douglas County Dispatch and request a callback from the on-duty Battalion Chief. LDCFM may delay, deprioritize, or decline these requests based on 911 system status. If a request is granted, fill out the question below:

(1) Can this patient safely be transported by car or wheelchair van (i.e., may safely sit during transport, without an attendant or monitoring?) ❑ YES ❑ NO

(2) Check all that apply to patient: ❑ UNABLE to get up from bed without assistance ❑ UNABLE to ambulate ❑ UNABLE to sit in a chair or wheelchair

(3) Describe the MEDICAL CONDITION(S) (physical and/or mental) AT THE TIME OF TRANSPORT that requires the patient to be transported in an ambulance:

_____

(4) List efforts to secure transport from a non-emergency ambulance service before calling LDCFM, and why those services are NOT being used for this patient:

_____

SECTION 5 – ROUTINE TRANSPORT

LDCFM does not perform routine medical transportation when an ambulance is not medically necessary. Request a medical transport service using your hospital's established procedures. If none is available, request a non-emergency (interfacility) ambulance service using your hospital's established procedures.

SECTION 6 – SIGNATURE OF PHYSICIAN OR OTHER AUTHORIZED HEALTHCARE PROFESSIONAL

I certify that the above information is accurate based on my evaluation of this patient, and that the medical necessity provisions of 42 CFR 410.40(e)(1) are met, requiring that this patient be transported by ambulance. I understand this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services. I represent that I am the beneficiary's attending physician; or an employee of the beneficiary's attending physician, or the hospital or facility where the beneficiary is being treated and from which the beneficiary is being transported; that I have personal knowledge of the beneficiary's condition at the time of transport; and that I meet all Medicare regulations and applicable State licensure laws for the credential indicated.

X _____ _____ _____

Signature of Physician or Authorized Healthcare Professional* | Printed Name and Credentials of Physician or Authorized Healthcare Professional (MD, DO, RN, etc.) | Date Signed

Any of these healthcare professionals may sign. Check the appropriate box:

❑ M.D. ❑ D.O. ❑ Nurse Practitioner ❑ Physician Assistant ❑ Clinical Nurse Specialist ❑ Registered Nurse ❑ Licensed Practical Nurse ❑ Social Worker ❑ Case Manager ❑ Discharge Planner